WellDyneRx Prescription Drug Claim Form

INSTRUCTIONS:

1. Fill out all of the information on the claim form as completely as possible.
2. **Please complete a separate claim form for each family member.**
3. Please include the original receipt with prescription details from your pharmacy when submitting the WellDyneRx Prescription Claim Form. Cash register tape and photocopies will not be accepted.
4. If necessary, contact the pharmacist to provide the detailed drug information requested on the form for the prescription(s) dispensed.
5. Please provide the complete name, address and telephone number of the pharmacy. Should you or the pharmacist have questions regarding the completion of this form, please call our toll-free number at 855-799-6831. We are available 24 hours a day, 7 days a week.
6. Claim must be filed within 365 days of the date the prescription was filled.
7. Mail the completed form and original receipts directly to:

   WELLDYNERX
   ATTN: Suffolk County Paper Claims
   PO BOX 90369
   Lakeland, FL 33804
8. You will receive a response within 30 days.

Use this form to be reimbursed for each prescription that you purchased without your prescription card.
You will be reimbursed the network pharmacy rates, minus co-pays.

EMPLOYEE INFORMATION		
Employer's Name	WDRXGRP#	
Last Name	First Name	Middle Initial
Identification Number		
Address		
City	State	Zip Code
Daytime Phone Number		

PATIENT INFORMATION		
Patient's Last Name	First Name	Middle Initial
Birthdate (m/d/y): _____/ _____ /_____		
Male ❑	Female ❑	
Patient's Relationship to Employee Self ❑ Spouse ❑ Child ❑ Other ❑		

PRESCRIPTION #1 INFORMATION		
Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg., ml., etc.)		
NDC Number:		
Is this Drug: (Check All That Apply) ❑ New Prescription ❑ Refill ❑ Compound Rx ❑ Allergy Injectable		

PRESCRIPTION #2 INFORMATION		
Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg., ml., etc.)		
NDC Number:		
Is this Drug: (Check All That Apply) ❑ New Prescription ❑ Refill ❑ Compound Rx ❑ Allergy Injectable		

PRESCRIPTION #3 INFORMATION		
Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg., ml., etc.)		
NDC Number:		
Is the Drug: (Check All That Apply) ❑ New Prescription ❑ Refill ❑ Compound Rx ❑ Allergy Injectable		

PRESCRIPTION #4 INFORMATION		
Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg., ml., etc.)		
NDC Number:		
Is the Drug: (Check All That Apply) ❑ New Prescription ❑ Refill ❑ Compound Rx ❑ Allergy Injectable		

PRESCRIPTION #5 INFORMATION		
Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg., ml., etc.)		
NDC Number:		
Is the Drug: (Check All That Apply) ❑ New Prescription ❑ Refill ❑ Compound Rx ❑ Allergy Injectable		

PRESCRIPTION #6 INFORMATION		
Rx Number	Date Filled	
Quantity	Days Supply	Amount Paid
Prescribing Doctor DEA Number or Name		
Medication Name and Strength (mg., ml., etc.)		
NDC Number:		
Is the Drug: (Check All That Apply) ❑ New Prescription ❑ Refill ❑ Compound Rx ❑ Allergy Injectable		

Pharmacy Name Address City State Zip Code

Pharmacy Telephone Number NPI Number

I certify that the information on this claim form is correct and authorize release of all information to WellDyneRx and the Plan Sponsor. I also certify that the patient for whom this claim is made is eligible for benefits and does not have primary prescription drug coverage under any other group medical plan. I verify that the drugs listed are not for treatment of an occupational injury or disease for which the Employer has accepted liability.

This form must be signed: _____

Employee/Member's Signature Date